buyers health care action group

BHCAG

2006

Minnesota Purchasers Health Plan Evaluation

eValue8 HEALTH CARE

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Executive Summary

buyers health care action group

BHCAG

The Buyers Health Care Action Group (BHCAG), on behalf of its members and the members of the Smart Buy Alliance, conducted a rigorous evaluation of five major Minnesota health plans from January through April 2006. The plans include Blue Cross Blue Shield of Minnesota, HealthPartners, Medica, Patient Choice and PreferredOne. Using a standard request for information survey, eValue8™ asks health plans to submit data about clinical quality and administrative efficiency so purchasers can compare plans against one another and against national benchmarks.

Hundreds of benchmarks are gathered in critical areas such as:

- Health information technology
- Member and provider communications
- Disease management
- Program administration
- Provider performance
- Patient safety
- Pharmacy management
- Behavioral health
- Financial stability

A certified eValue8™ scoring team verifies the health plan information to ensure that all the information is accurate and comparable. Purchasers take the information to meetings with each of the health plans to discuss strengths, best practices and opportunities for improvement. Employers working through coalitions also use the information to discuss community-wide opportunities for health improvement through collaboration.

Background

Eleven years ago, several coalitions, including BHCAG, and large employers across the country gathered to develop a way for purchasers to buy health care and evaluate health plans based on real value, not just on price.

The concept of quality was introduced and has become the overarching principle in the eValue8™ buying process. ***More than 100 health plans across the country now participate in this process.***

Key Minnesota Health Policy Issues

In addition to evaluating health plans on ten specific health care domains, the 2006 report identifies four health care policy concerns. The transformative nature of eValue8™ helps guide BHCAG in setting community-wide quality improvement goals to improve Minnesota's health care system. These issues include:

- **Health Disparities -** Racial, cultural and language health disparities affect the entire community. A stable workforce depends now, more than ever, on the health of the entire public. It is also important to improve care to underserved populations enrolled in public programs to decrease the overall tax burden to support these expanding programs.
- **Health Information Technology (HIT) -** the health care industry is woefully behind in building an information infrastructure that ensures interoperatability, continuity of care and the ability for providers and consumers to access health information when they need it. The entire marketplace must aggressively pursue strategies and support federal and state initiatives to ensure health information and patient records can easily be shared within the system.
- **Pay for Performance -** the current payment system pays providers for procedures, not results. Health plans must partner with purchasers to adopt common quality measures needed to realign the payment system with incentives and provider rewards to drive quality improvement and cost control.
- **Consumer Engagement** - today's healthier and more involved consumer requires searching tools and quality information to manage their health and health care decisions.

Why eValue8™?

Employers ultimately use the information gathered through eValue8™ - *comparative charts and knowledge gained through site visits* - to compare value, based on their own selection criteria. Some employers use the information to negotiate pricing with health plans. Some use the information to set employee premiums, with higher quality health plans costing less. Equally important to pricing, employers working with coalitions use the information and the subsequent feedback with health plans as a unique opportunity to stimulate market-wide improvements in health care quality. ***Members who subscribe to eValue8™ have access to question-by-question plan responses as well as a detailed analysis of each plan's strengths and opportunities for improvement.***

Value-Based Purchasing

A number of public and private purchasers are adopting a value-based purchasing framework that emphasizes quality and efficiency as major criteria for selecting health plans. Employers who use the eValue8™ tool significantly reduce expense, time and consultant fees normally associated with gathering, analyzing and reporting health care performance data on their own.

Common Specifications

Over the past five years, a group of coalitions and their purchaser members have been working to develop common health plan specifications and criteria to be applied across all communities. These common specifications and criteria create the eValue8™ tool that is used to assess health plan performance and guide purchase decisions and quality improvement goals.

National Comparative Database

The National Business Coalition on Health, a national non-profit network of 7000 employers and purchasers represented through coalitions, is the formal sponsor of the eValue8™ tool to ensure stability and broad application across the United States. eValue8™ has also expanded through a joint effort with Watson Wyatt. eValue8's is also supported by the NCQA, Centers for Disease Control, the Substance Abuse and Mental Health Services Administration, the Centers for Medicare and Medicaid, George Washington University and Penn State University.

eValue8 HEALTH CARE

eValue8™ seeks to:

•Establish common information requests to health plans from purchasers and to the degree possible, reduce the number of varied requests that consume health plan resources.

•Improve the level of comparative information (i.e., costs, quality and value) available to purchasers.

•Reduce unnecessary costs, improve access to appropriate services and measurably improve the quality/outcomes of health care services.

•Establish information, benchmarks and other quality improvement sharing activities that will improve the delivery of health services for enrollees and the entire community.

•Develop performance and accountability standards in health vendor agreements with coalitions and purchasers.

•Whenever possible use developed measures and data collection means that already enjoy high level consensus and process by quality oversight organizations (e.g. NCQA, JCAHO, URAC etc.)

•Draw upon and disseminate the expertise, innovations and "best practices" represented by health vendors.

•Provide consumers with performance information which will aid them in the selection of health plans, practitioners and treatment.

BHCAG's Legacy

Transformative Strategies To Change Minnesota's Health Care Marketplace

Since forming in 1988, BHCAG's mission has been to move the health care marketplace towards value-based purchasing so consumers can get the care they need in the right place, at the right time and at the right price. In 1992, BHCAG first introduced standardized health care specifications and measurement by creating **Choice Plus,** a tiered health care benefit program that encouraged long-term patient/provider relationships, improved quality and consumer education. BHCAG employers agreed to use the same benefit plan design, share a common claims administrator and uniform performance expectations to measure the quality of care. The Institute for Clinical Systems Improvement (ICSI) was formed in direct response to BHCAG's stipulation that all care systems have continuous quality improvement programs in place. Although implementation of the ICSI practice guidelines is voluntary, virtually all of the care systems and Minnesota health plans now use these proven treatment guidelines. This streamlined approach made it easier for providers to participate in the Choice Plus program and clearly understand performance expectations.

Broadening Scope to Health Plans

In an effort to spur real transformation across the entire health care marketplace, BHCAG now uses eValue8™ to ensure all stakeholders, including health plans, pursue quality-focused partnerships with health care purchasers. The eValue8™ tool provides the common vehicle for purchasers and health plans to use their buying power and influence to reform the health care system. eValue8™ embraces widely accepted business purchasing principles that involve standard product specifications to streamline markets, increase quality, base payment on performance and lower input costs. BHCAG issued its first eValue8™ public report in 2005 to support the widespread adoption of common performance measures and practice guidelines in the health care marketplace. ***A strong indication of this employer/health plan partnership is that Minnesota health plans in 2006 posted "national best" scores in six of the ten eValue8™ survey domains.***

Quality Principles Take Hold In the Community

The outgrowth of eValue8™ in Minnesota has led to the formation of the following large-scale purchasing partnerships and innovative quality initiatives:

•**The Smart Buy Alliance** - an unprecedented partnership of state government and private employers to mobilize the purchasing power of three out of every five Minnesotans to raise the quality, improve the efficiency and reduce the cost of health care.

•**Bridges to Excellence** - an employer-led pay for performance program that rewards doctors for optimal care for chronic illness such as diabetes and cardiovascular disease.

•**QCare -** a plan implemented by Governor Tim Pawlenty to base Minnesota's annual $4 billion state health care expenditures on provider performance and better health outcomes. This is a signficant expansion of value-based purchasing that insists on common measures, pay for performance and public reporting of quality to benefit consumers of health care.

The eValue8™ Survey

Consistency, Stability and Broad Application

eValue8™ provides the framework to transform the current health care system's fee-for-service focus to a pay for performance structure where providers have strong incentives to improve care, consumers have comparative information to choose high quality doctors and employers voice common expectations to the health care marketplace.

eValue8™ asks health plans to submit online annual standardized reports - with extensive documentation - that measure their performance in a number of clinical areas and administrative practices. The information is then verified so purchasers can compare the plans against each other as well as to national benchmarks. Purchasers also provide feedback to health plans and health care providers to help identify quality improvement opportunities.

The areas covered in the eValue8™ online health plan survey include:

• **Health Information Technology** –plans are asked if physicians and nurse practitioners have access to PDAs and computer software to order patient prescriptions and prevent drug conflicts. The plan is also asked what information technology is used to process claims and communicate claim costs to employers by various disease categories.

• **Consumer Engagement and Support** –asks plans how many tools they offer consumers to manage their health and their health care decision such as offering 24/7 nurse advice/health coaching, automated "push" emails based on member disease or condition and online enrollment in disease management programs.

• **Provider Measurement** - plans are asked if they partner with other health plans in the community on patient safety programs and what they do to track and benchmark performance for both doctors and hospitals.

• **Primary Prevention and Health Promotion** – plans are asked about the extent of involvement in community collaboration on cancer screening, immunizations, tobacco, weight management, worksite health promotion and risk factor education.

• **Chronic Disease Management** - plans must document the programs they use to help their members with asthma, cardiovascular disease and diabetes manage their conditions. The survey asks if outbound phone calls are used to remind these patients and the specific triggers that prompt the plan to contact the patient.

• **Behavioral Health** – plans are asked if they promote established clinical guidelines and best practices for depression management and alcohol disorders. The plans report whether they measure provider performance results in behavioral health and the extent of their patient support and education programs.

• **Pharmacy Management** – plans report on their relationships with pharmacy benefit management firms, how they manage costs through generic equivalent prescriptions, whether or not they have programs to address specialty pharmaceuticals and the steps they take to maximize pharmacy safety at the prescribing and patient level.

• **Consumer-Directed Health Plans** – plans report on the flexibility consumers have in choosing elements important to them and the tools plans offer to users of these high-deductible plans and health savings accounts.

How Employers Use eValue8™

Employers can use eValue8™ in a number of strategic ways to influence their health care purchasing decisions. Employers and health care coalitions in other parts of the country reveal they use eValue8™ to:

Evaluate and price health plans

Some employers, including General Motors and Pitney Bowes, use the information to determine how much the company will contribute to the employee share of the premium. High quality plans with high customer satisfaction scores are presented to employees as a more affordable choice. In this case, both the employer and employee win because the employee is financially encouraged to choose a high quality plan.

Improve health

Many coalitions, including BHCAG, utilize the information from eValue8™ to develop community-wide collaboratives to improve the health outcomes associated with certain chronic illnesses such as diabetes, asthma, and coronary artery disease.

Encourage health plan and purchaser partnerships

Health plans have tremendous influence on health care providers through the negotiation of payments and numbers of patients. The eValue8™ process turns health plans into smart purchasing partners by specifying the type of performance data health care providers must track in the delivery of health services.

Blue Cross Blue Shield of Minnesota leaders discuss their eValue8™ results with BHCAG employers during a May 2006 site visit.

eValue8™ Site Visits

Once the health plan submits the data and it has been verified, individual **site visits** – *meetings involving health plan leaders and eValue8™ subscribers* - are held to discuss the particular plan's results and identify areas for improvement and collaboration.

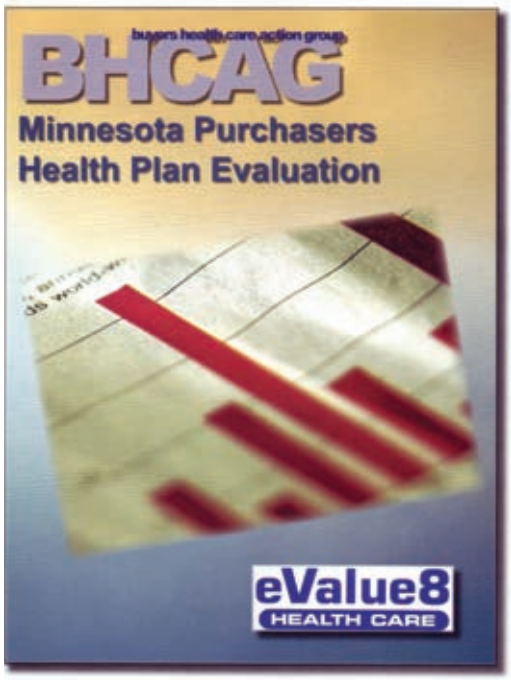
Reports including charts comparing the various health plans against each other are presented so health plan leaders can gauge their srengths and areas needing improvement. This rare face-to-face encounter lets employers directly convey their purchasing expectations to health plan vendors and make purchasing decisions based on health plan performance in these key value-based purchasing areas.

The additional benefit of these meetings is that the eValue8™ measures also convey the common specifications and benchmarks that provide the best promise for improving quality and value for ***all*** stakeholders in the community.

eValue8™ in Minnesota

With eValue8™'s standardized specifications and performance measures, Minnesota health care providers will be able to deliver care with greater efficiency and better health outcomes for patients. BHCAG is using eValue8™ to stimulate the widespread adoption of common performance measures and practice guidelines in the health care marketplace. This will help the public gain better value for their health care dollar and to stimulate quality improvement throughout our Minnesota and Upper Midwest communities.

Participating Minnesota Health Plans



In January 2006, BHCAG sent the eValue8™ survey to health plans in Minnesota and the Upper Midwest. Five health plans completed the eValue8™ survey and include:

- Blue Cross Blue Shield of Minnesota
- HealthPartners
- Patient Choice
- Medica
- PreferredOne*

The plans submitted information on the following individual HMO and PPO products:

- HealthPartners HMO and PPO
- Blue Cross Blue Shield of Minnesota PPO
- Medica HMO and PPO
- Patient Choice PPO
- PreferredOne PPO*

Survey Familiarity

*BHCAG first introduced eValue8™ in 2002 and found that health plans were able to provide clearer responses and more usable information for purchasers once they became accustomed to the complexity of the survey questions. 2006 was the first year PreferredOne participated in the survey. While all of the PreferredOne data is available to members who subscribe to eValue8™, BHCAG does not publicly report the first year results of participating health plans since their results would not be an accurate comparison against other plans who have had previous experience with the survey.

Health Plan Acceptance of eValue8™

An indication that Minnesota health plans have embraced eValue8™ as a quality improvement barometer is that Minnesota health plans rank "national best" in ***six of the ten*** eValue8™ health domains that comprise the 2006 eValue8™ Report.

2006 Community-Wide Health Improvement Opportunities

BHCAG builds on Minnesota's legacy of collaboration in health care improvement. We use eValue8™ to create common community goals for marketplace reform. In pursuit of greater community-wide collaboration between purchasers, providers, health plans and public policy leaders, the 2006 eValue8™ results point to a number of health improvement initiatives that are necessary to continue Minnesota's momentum in creating a health care system that delivers better health and better value.

These initiatives include:

Narrowing Health Disparities

The eValue8™ report shows that Minnesota excels in number of areas but health disparities is not one of them. More effort should be made by plans to decrease racial, cultural and language disparities that result in lower quality of care and economic consequences when patients who are unable to understand health professionals' instructions wind up in costly emergency rooms.

Expanding Provider Pay for Performance

The cornerstone for better care is a value-based purchasing strategy built around pay-for-performance, transparent price and quality information and common purchasing tools - such as eValue8™ - that places a common "purchase order" for services that have been proven to stabilize costs and keep quality high. Health plans must expand their partnership with purchasers in this shift from a payment system that pays for procedures to a system that pays for results. By supporting employer-led, pay-for-performance initiatives like ***Bridges to Excellence*** and ***QCare***, Minnesota health plans will ensure their members have access to a wide array of high-performing health care providers.

Accelerating Interoperable Health Information Technology

eValue8™ confirms the health care industry is not moving fast enough to improve the information infrastructure that ensures interoperability, continuity of care and the ability for providers and consumers to access health information. BHCAG will continue to support statewide initiatives to make Minnesota a national HIT leader including the **Minnesota eHealth Initiative** and the **Minnesota Health Care Connection** - a nonprofit created out of the MN ehealth initiative to "focus on interconnecting clinicians, consumers, payers and other health stakeholders for the purpose of electronically exchanging accurate and standardized health information."

Increasing Consumer Engagement

Health care in the future will depend on an informed consumer and today's healthier and more involved consumer requires sophisticated searching tools and provider quality information to manage their health and their health care decisions.

(Detailed strategies and goals for each opportunity are discussed in the following section.)

Critical Health Policy Concerns

Narrowing the Health Disparities Gap

The 2006 eValue8™ survey asked health plans to answer questions about their efforts to reduce racial, cultural and language health disparities in Minnesota. There is ambiguity surrounding the definition of "health disparities", but no ambiguity about its existence. The Institute of Medicine (IOM) has defined health disparities as "differences in the treatment of individuals from different groups when the differences are not justified by clinical appropriateness or by patient preference." In contrast, the National Institute of Health defines health disparities as "differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States."

Regardless of the definition, health disparities exist in Minnesota:

•African American, American Indian, and Asian/Pacific Islander women in Minnesota are three to four times more likely than white women to have cervical cancer even though routine screening can prevent it.

•African Americans are more than twice as likely to die from diabetes compared to whites even though the disease can be managed by controlling blood sugar, blood pressure and cholesterol.

•Infant mortality rates in Minnesota are two to three times higher among American Indian and African American communities compared to whites.

The significance of these disparities are compounded by the fact that Minnesota's African American population is projected to double while the Asian/Pacific Islanders and Hispanic populations are expected to triple by 2025.

Proof of Cultural Competence

eValue8™ is currently the only purchasing tool that addresses racial, cultural and language disparities in our health care system. eValue8™ asks health plans for specific proof that they know the racial and cultural composition of their membership and what steps they take to measure and address differences in treatment patterns and disease incidences. For example, eValue8™ places signifcant emphasis on eliminating language barriers. Even patients without language challenges rarely tell the doctor if they don't understand his or her directions. If a doctor can clearly communicate treatment and prescription instructions, the patient will be able to comply thus reducing differences in disease incidence and treatment options. Health plans must disclose whether they certify that providers in their network know various languages and whether they provide customer service assistants who are certified in a number of languages.

Minnesota Health Plan Performance

Minnesota health plans excel in a number of health domains, but must improve their performance in health disparities. Minnesota HMOs rank below the national eValue8™ average of 17.45 points out of a total of 25. The Minnesota HMO score was 16.69. Minnesota PPOs perfom slightly better with a score of 17.45 against a national average of 15.35.

Minnesota health plans should support the Minnesota Department of Health "Eliminating Health Disparities Initiative," which is intended to "close the gap in the health status of African Americans/Africans, American Indians, Asian Americans, and Hispanic/Latinos in Minnesota compared with whites. The priority health areas in this initiative include: breast and cervical cancer, cardiovascular disease, diabetes, HIV/AIDS and sexually transmitted infections, healthy youth development, and violence and unintentional injuries. The Minnesota Council of Health Plans has also launched targeted health disparity programs that health plans can use to reduce racial, cultural and language health dispartities.

Health Information Technology - Connectivity for the Consumer's Benefit

Health information technology (HIT) provides the foundation for the value-based purchasing strategies employers are pursuing to ensure a safe, timely, efficient, effective and patient-centered health care system. The eValue8™ tool reflects this fact by measuring health plans with respect to:

The Carlson Companies in 2006 pioneered the use of ***MyHealth Folio*** - a community based personal health record provided as an employee benefit, but "owned" and managed by the employee.

•**Interoperability Standards -** the extent health plans HIT systems are able to communicate with other plans and providers to improve patient care on a community-wide basis

•**Community Collaboration -** health plans identify their participation in local and regional health information organizations, common security standards and community-wide electronic prescribing.

•**Practitioner Support -** how the health plans support practitioners administratively and clinically by providing online systems to determine patient eligibility, track submitted claims, make specialist referrals, and order and view lab and radiological test results.

•**Member Support -** if the health plans provider IT tools to members. If the tools include personal health record the content and source of the content is identified.

•**Health Outcomes -** health plans are expected to monitor and show an increase in the use of electronic forms of communication and information exchange compared with other forms of transaction. They are also expected to track member and practitioner satisfaction with online systems and information services.

Minnesota Health Plan Performance

Minnesota plans compare well against other health plans on eValue8™ HIT measures (national average is 3.96 vs Minnesota average of 5.5). However, a recent **Robert Wood Johnson Foundation Market Scan of Quality Initiatives** ranked Minnesota last in implementation of collaborative HIT initiatives. It is imperative that health plans adopt interoperable HIT standards that the American Health Information Community (AHIC) has developed so health information and records can be shared much more easily within the health care system. Connectivity and a common framework are the critical HIT concerns for Minnesota. Plans should not spend premium dollars on redundant projects intended to provide a competitive advantage and impede information sharing between all stakeholders in the health care system. HIT initiatives should focus on the common good so information will flow between providers and health plans for the benefit of all consumers.

Three Minnesota HIT initiatives that support a common HIT framework include:

•**Minnesota eHealth Initiative:** a public-private collaboration with the purpose of accelerating the adoption and use of health information technology to improve patient health, increase patient safety, reduce health care costs and improve the health of the entire community.

•**Minnesota Community Measurement:** a collaboration of providers and health plans which publicly reports the performance of physicians in more than 700 clinics in Minnesota.

•**Minnesota Health Care Connection** - a nonprofit created out of the Minnesota eHealth Initiative to focus on interconnecting clinicians, consumers, payers and other health stakeholders for the purpose of electronically exchanging accurate and standardized health information.

Minnesota health plans could help accelerate and enhance these initiatives by becoming funding partners to support the development of the common network needed to ensure effiicient transmission and utlization of health care data.

Pay for Performance

Rising costs and mounting evidence of quality problems are unacceptable and unsustainable features in today's health care marketplace. BHCAG members have been working aggressively to create a health system based on a structure that pays providers for results, not the number of procedures. Surveys such as eValue8™ reveal that medical treatment and health care quality vary significantly between medical groups and health plans.

Better care can be ensured through a combination of proven clinical measures and financial rewards that encourage doctors to take a more thorough and systematic approach to treating patients for illnesses and conditions. In return for their commitment, doctors who meet the rigorous care goals must be publicly recognized for their performance so consumers will know who to seek for better treatment.

eValue8™ gives employers a platform to pay for the right things by measuring health plans and provider performance in in key disease areas. Specifically, it measures health plans on the incentives and programs they have in place to reward providers and hospital organizations based on their performance. For example, health plans are scored higher if they offer financial bonuses, better fee schedules and capitation rates and market share programs that direct members to use high-performing providers. This could be accomplished through lower co-pays and deductibles or by creating a special high-performance provider network.

Minnesota Health Plan Performance

Minnesota HMOs and PPOs rank significantly higher in physician pay for performance than their national counterparts. Out of 14 total points available for physician performance rewards, Minnesota HMOs scored 11.42 while the national average was 7.27. Minnesota PPOs received 11.65 points compared to a national average of 7.3 On rewarding hospital performance, Minnesota HMOs and PPOs also rank higher than the national average. Minnesota HMOs scored 7 out of 12 points while the national average was 4.07. Minnesota PPOs scored 9.9 while the national PPO average was 5.81.

Minnesota health plans should help employers and public purchasers adopt and expand the following major statewide pay-for-performance initiatives:

Bridges to Excellence - an employer-led pay for performance program that pays doctors for optimal care of diseases such as diabetes and heart disease. The Minnesota Bridges to Excellence effort involves public and private employers including the State of Minnesotam the Carlson Companies, General Electric, Honeywell, 3M, and Wells Fargo. In 2006, nine health care systems in Minnesota and Western Wisconsin have earned cash rewards for meeting the stringent Bridges to Excellence treatment goals. BHCAG will add cardiovascular disease performance rewards next year and we urge Minnesota health plans to support this effort.

QCare – Quality Care and Rewarding Excellence – a new plan to base all Minnesota state program health care expenditures on pay for performance and better outcomes. QCare embraces many of the pay-for performance and public reporting initiatives BHCAG has launched to increase quality and control costs. Similar to BHCAG's Bridges to Excellence and eValue8™, the QCare program identifies quality measures, sets aggressive targets for health care providers, makes measures available to the public online, and improves the payment system by rewarding quality rather than quantity.

Consumer Engagement

Expanding consumer choice - *choice of providers and choice of treatments* - has been the overarching goal of BHCAG's value-based purchasing agenda. Minnesota's economic future and quality of life depend on informed citizens and today's healthier and more involved consumers require sophisticated searching tools and provider quality information to manage their health and their health care decisions. The hallmark features of a true consumer-driven health care system include price and quality transparency so individuals can "shop" for the services they need based on their personal preferences and priorities.

Individuals with Consumer-Directed Health Plans require easy-to-acess, transparent price and quality information - a weak area for many products.

One key policy concern surrounds the rapid introduction of consumer-directed health plan products that feature high-deductibles and health savings accounts. These health benefit products require that community-wide price and provider quality information be made available in a transparent, easy-to access manner so consumers can make informed choices about their health and their health care treatment decisions. eValue8™ insists that health plans offer tools allowing patients to customize medical treatment information for their specific medical conditions to narrow down the vast amount of unrelated health care information. For example, health plans are scored higher if they offer decision tools that compile patient-specific clinical information about a disease or condition that includes a medical literature review along with the risks and benefits of various treatment options.

Minnesota Health Plan Performance

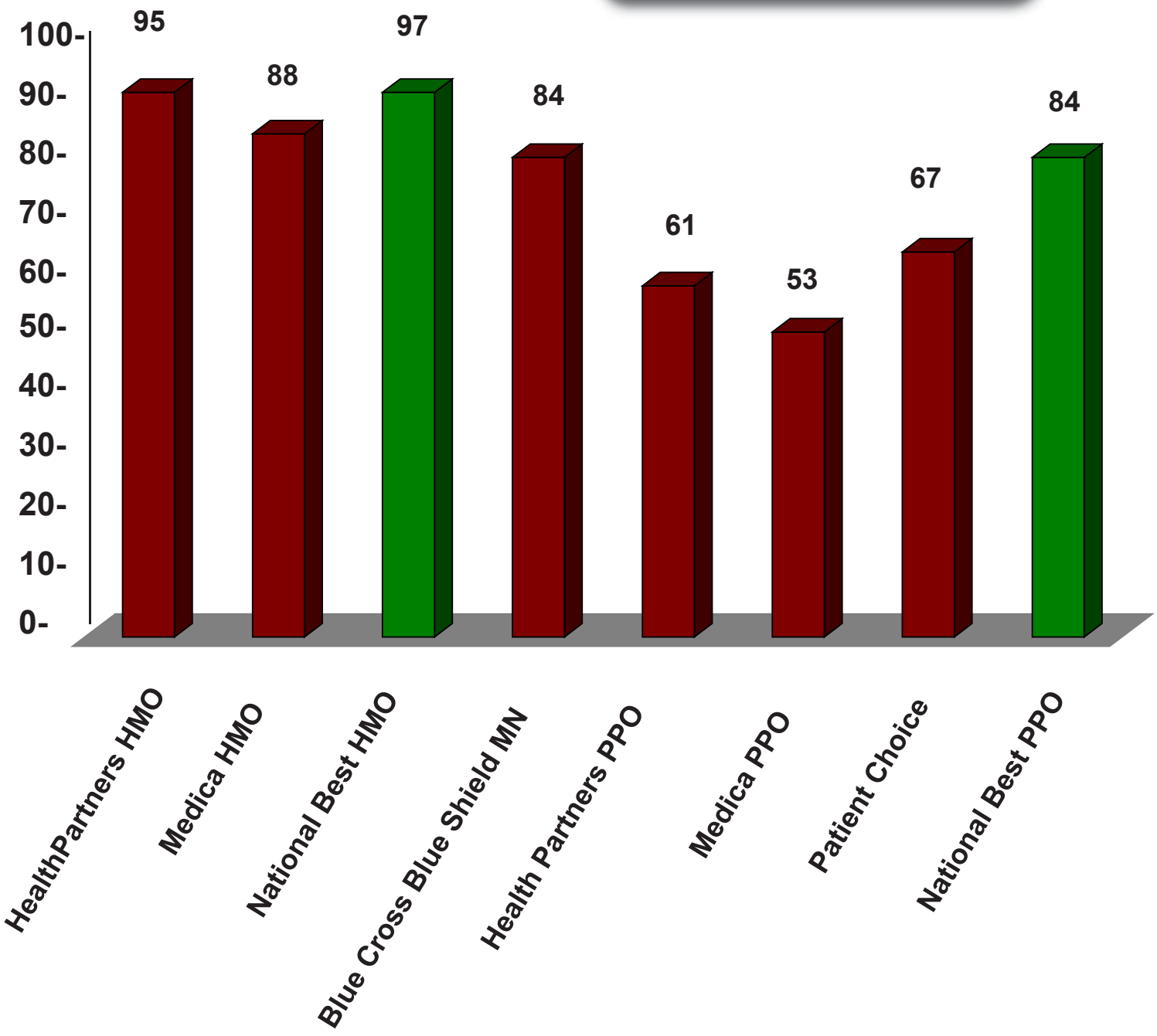
Minnesota health plans rank better than the national average in providing transparent practitioner performance information to consumers, but score equal or lower than average on hospital performance transparency and shared decision-making tools. The Minnesota HMO average for practitoner transparency was 15 out of 18 total points against a 7.75 national health plan average. However, in shared decision-making, Minnesota HMOs received less than half of the total 21 points available (10.33) with a national average of 12.96 in this important consumer engagement category. Minnesota health plans have a great opportunity to become national leaders in provider quality and decision-making tools by building upon pioneering performance measurement initiatives such as the Adverse Events Reporting Act, Leapfrog Group hospital patient safety indicators and ***Minnesota Community Measurement*** that reports the performance of providers in more than 700 clinics throughout the state. The future focus for eValue8™ will be to encourage health plans to improve the navigation and features they provide to help members choose better health care. This will include a deeper analysis of the useability of such tools and how well their use is promoted with patients and providers. eValue8™ will measure the extent to which a health plan allows a member to set his or her own preferences and needs in searchable provider and quality tools. It will also require health plans to elaborate on the information contained in reports including whether or not the plan can provide mortality rates and evidence-based hospital referral that lists hospitals with extensive experience and better results for high-risk treatments and surgeries.

Plan Results

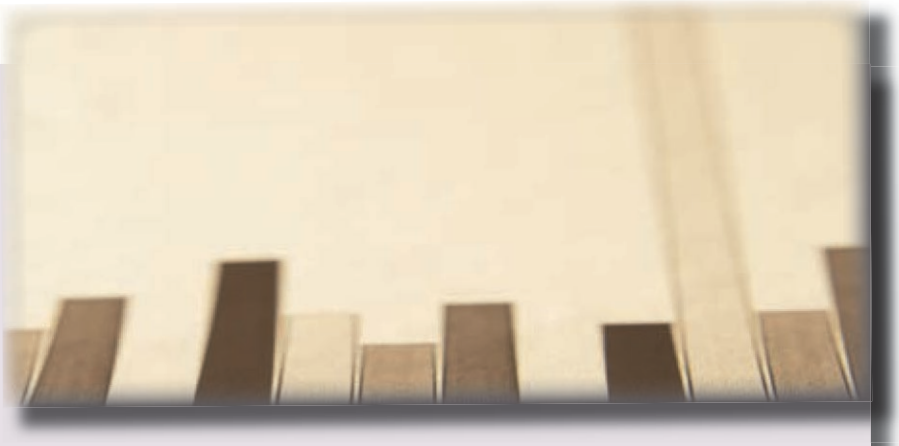
Plan Profile

2006 eValue8™ National Best

Blue Cross Blue Shield of Minnesota PPO scored the highest in this eValue8™ category.



What's Measured?



Participating Minnesota health plans submitted online annual standardized reports that measure their performance in a number of clinical areas and administrative practices. ***The information was tabulated and is presented in the following graphs so purchasers can compare the plans against each other and to the best national health plan with the highest performance score in the country.***

Accreditation

Health plans and their vendors earn many of the points in this category by undergoing accreditations and reviews. The National Committee for Quality Assurance (NCQA), an independent health care accrediting body in Washington, D.C., does one such accreditation. NCQA collects data and checks patient records to determine various levels of accreditation. Health plans with the highest level of accreditation that also participate in NCQA's Quality Plus program receive the best scores.

Community Collaboration

It is insufficient for plans to promote the use of evidence-based clinical guidelines, measure performance of doctors against those guidelines, and reward doctors for better performance without collaborating with other plans in the same market. If plans take these steps independent of one another, then they can create confusion for physician practices that may need to adhere to multiple guidelines for the same condition. When physicians have multiple guidelines to follow for the same condition, they often do not pay attention to any of them. Purchasers expect plans in the same market to send clear and aligned performance expectations to doctors and hospitals in order to drive improvements by leveraging their efforts collectively and consistently.

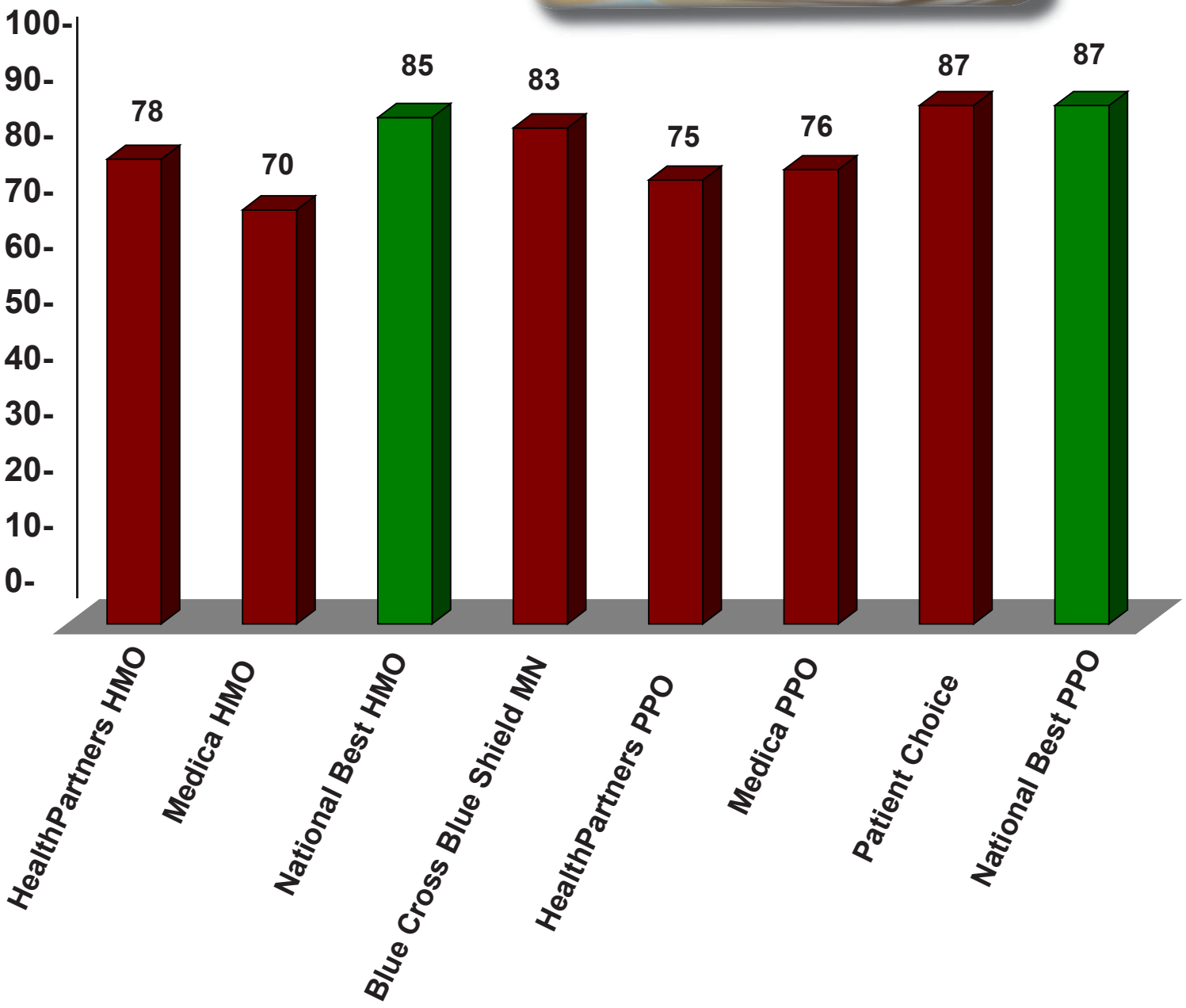
Disparities

eValue8™ determines the level of a health plan's measurement and response to racial, cultural and language differences as they relate to access to care, responses to specific treatments, and understanding what members must do to comply with care plans. Health plans must show they have established programs to address these issues.

Consumer Engagement & Support

2006 eValue8™ National Best

Patient Choice PPO scored the highest in this eValue8™ category and was awarded the first annual ***Driving Value in Health Care*** Award from the National Business Coalition on Health.



What's Measured?

Member Ratings

eValue8™ captures standardized survey results revealing how the plan's members rate the plan. Survey questions help to reveal consumer frustration levels, problems with paperwork, and barriers that members must navigate to get care from specialists and other health care providers.

Practitioner Information

Purchasers expect health plans to give consumers extensive information about doctors and other health care providers in their networks. Health plans are scored on the extent of their provider information listed in their print and online provider directories.

Facility Performance

Plans are expected to facilitate the consumer's hospital choice by providing quality, safety, and experience information. This section determines whether the plan encourages members to use hospital reports revealing compliance with patient safety standards.

Shared Decision Support

Health plans are evaluated on the services they provide to members to support special. treatment decisions. Plans are expected to provide an interactive service that members can use to help them make decisions about treatment options and strategies to manage their conditions. eValue8™ determines whether plan members can view information online about paid and pending claims and progress on deductibles and coverage limits.

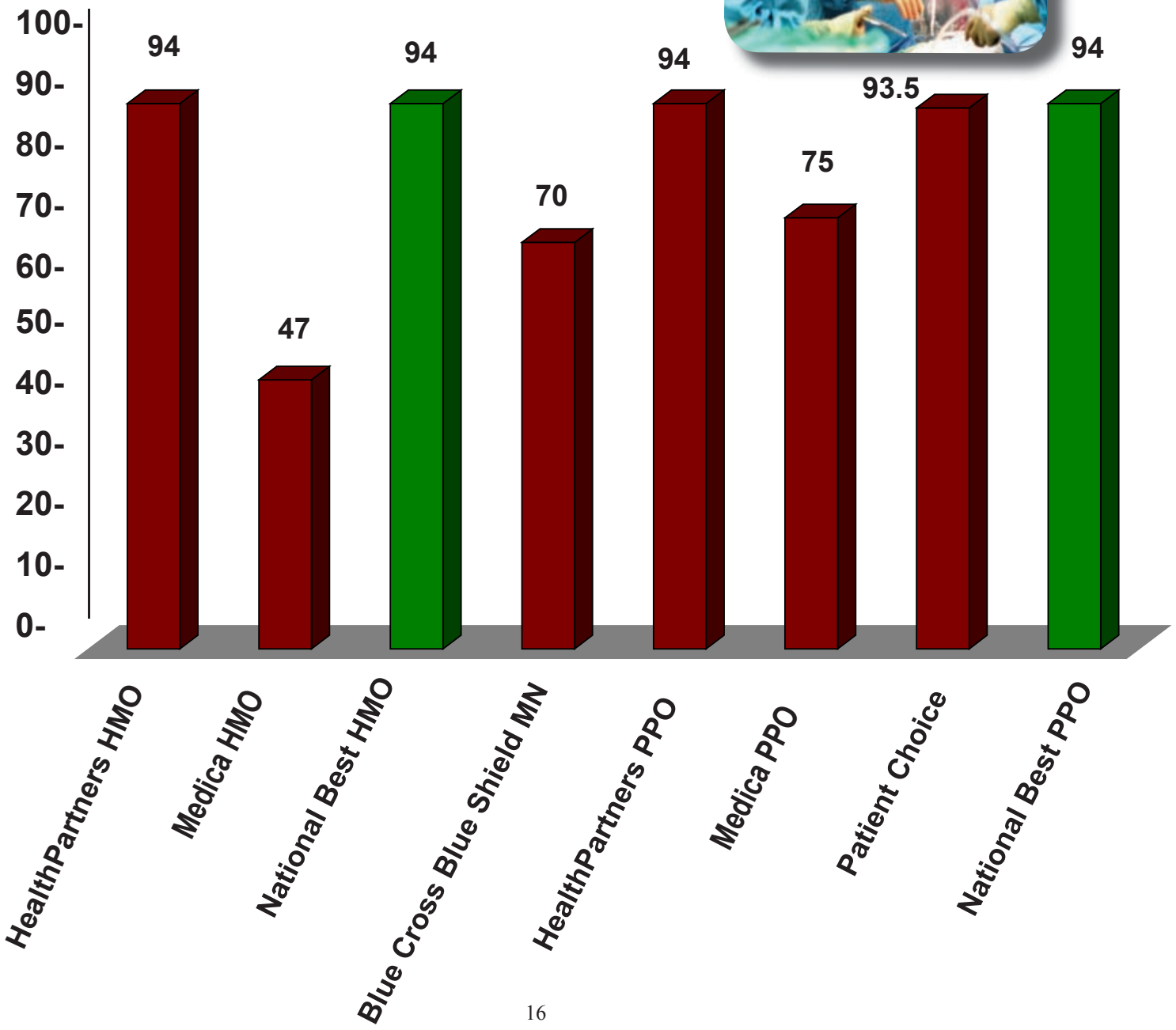
Pharmacy Management

eValue8™ determines whether health plans provide members with information on drug-drug interactions, generic-equivalent cost calculators, and guidance on selecting alternative medications, over-the-counter medications and information regarding preferential reimbursement for using certain pharmacies.

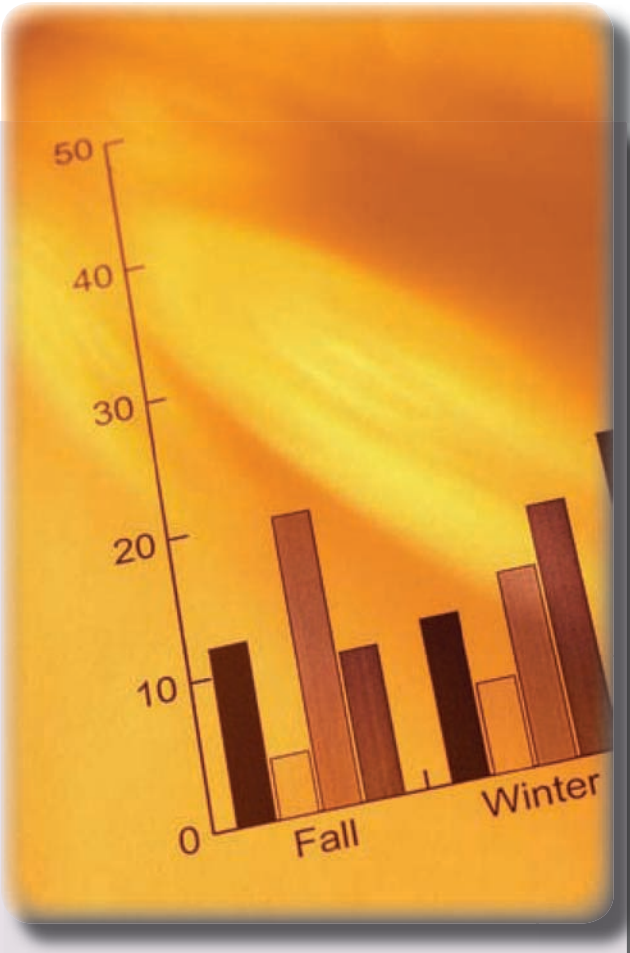
Provider Measurement

2006 eValue8™ National Best

HealthPartners HMO and PPO scored the highest in this eValue8™ category.



What's Measured?



Practitioner Performance

The physician performance section asks health plans about the clinical performance measures plans use to track physicians and physician groups. eValue8™ asks about utilization, efficiency, and outcome and process measures for a long list of conditions, such as hyperlipidemia, hypertension, coronary artery disease, and cancer. Plans are expected to report these measurement results to both group and individual practitioners.

Hospital Performance

This section asks health plans about the utilization, efficiency, safety and clinical performance measures used to track hospital performance. The section includes the entire set of Leapfrog hospital patient safety indicators. Plans are encouraged to make hospital performance results available to members, physicians and the public at large.

Incentives and Provider Differentiation

Health plans are asked to disclose the events and programs they use to reward and publicly recognize their network doctors and hospitals for high performance. For example, eValue8™ inquires if the health plans offer direct financial incentives or plan design incentives that steer members to high performing providers.

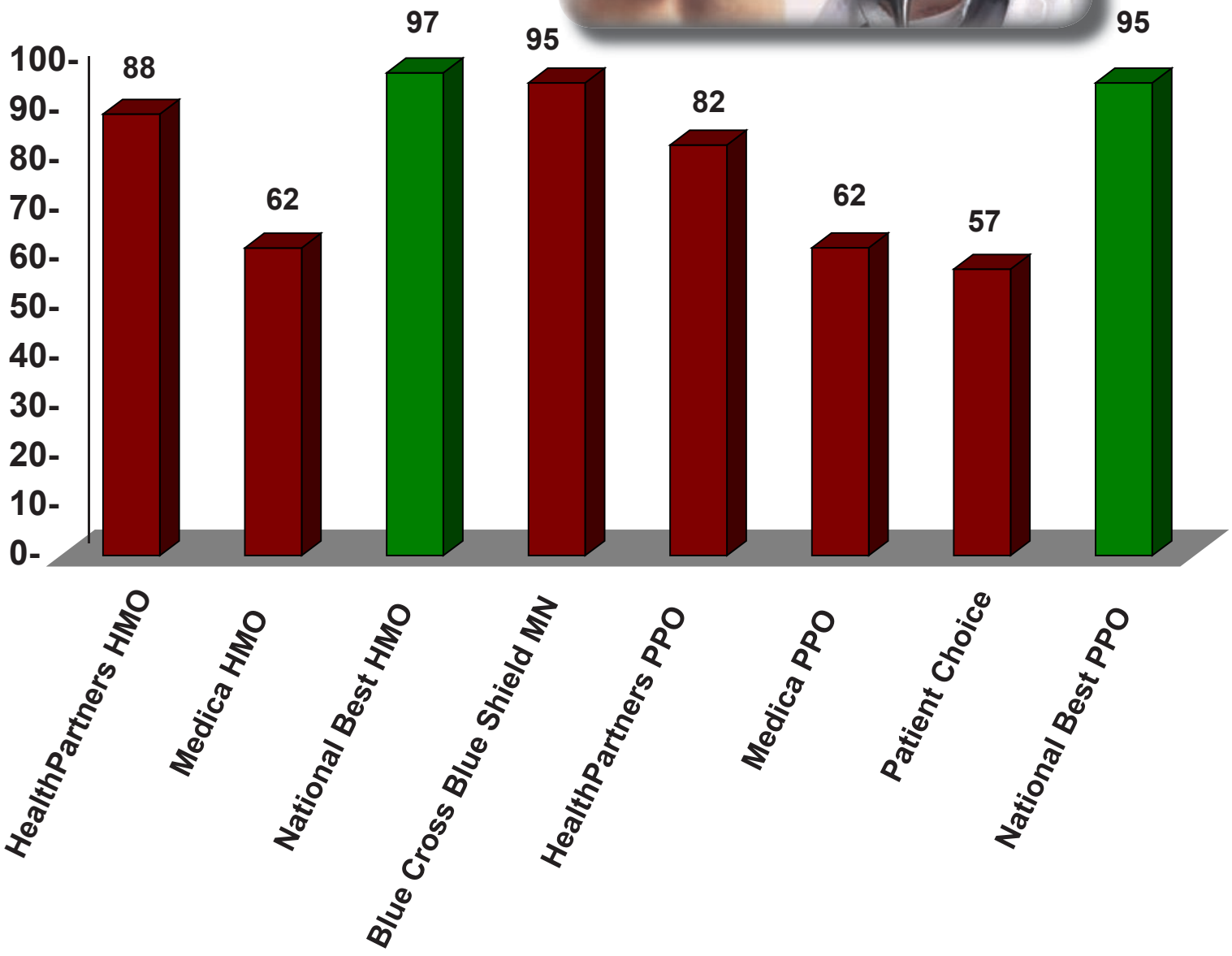
Centers of Excellence and High Performance Networks

This section examines whether the health plan has centers of excellence, meaning a selection of hospitals that perform better on high-risk medical procedures such as organ transplants and heart surgeries. Plans reveal the basis of their selection decisions, which should include evidence-based data such as mortality rates, volume, and complication rates. High performance physician networks also are emerging and eValue8™ captures information about these networks, including their selection criteria..

Chronic Disease Management

2006 eValue8™ National Best

Blue Cross Blue Shield of Minnesota PPO scored the highest in this eValue8™ category.



What's Measured?

The plan is asked to describe its disease management program organization, including the use of outside vendors that focus on asthma, coronary artery disease (CAD) and diabetes.

Member Support

eValue8™ measures how well health plans perform in providing assistance to members who have chronic conditions. For instance, health plans are scored on whether they remind diabetic patients to schedule routine visits and lab tests and if they provide follow-up reminders to patients who miss appointments or tests. Other services eValue8 looks for include one-on-one counseling, live, outbound phone calls to members, and the circumstances that prompt the health plan to contact members.

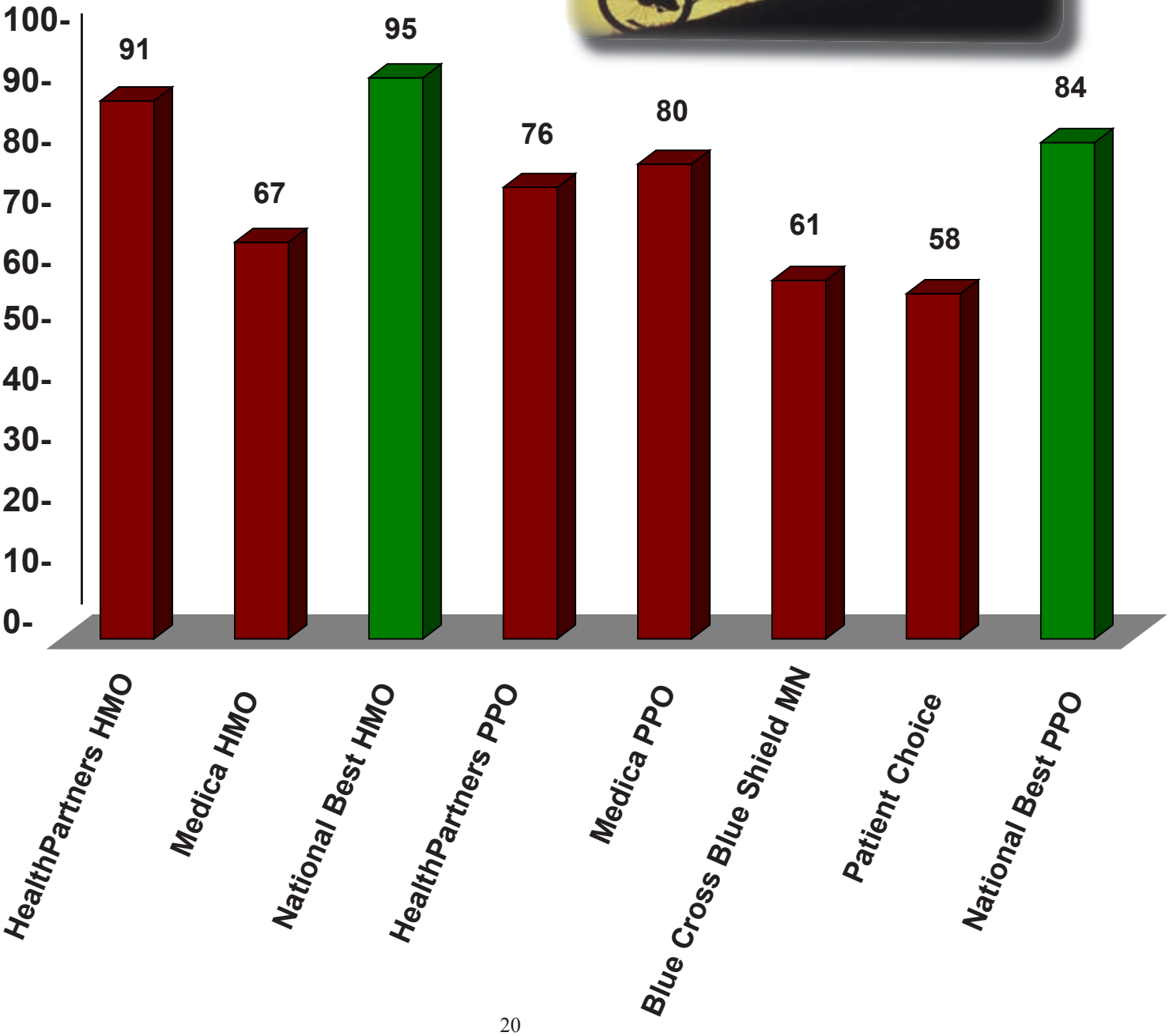
Practitioner Support

eValue8™ determines whether the plan gives its practitioners actionable patient-specific reports on their adherence to clinical guidelines and reports that compare the rates of adherence among practitioners with that of their peers.

Outcomes

eValue8™ examines a health plan's performance on measures for asthma, coronary artery disease, and diabetes from the Health Plan Employer Data and Information Set (HEDIS). NCQA collects and reports HEDIS data, which provides a standard set of condition-specific process and outcome measures that are audited and reported nationally. HEDIS results from more than 200 plans nationally are used to determine eValue8 scores in this category. eValue8™ also identifies whether the plans measure other outcomes of their chronic disease programs such as employee absenteeism, productivity, program return on investment, and patients' experiences with the program. Plans are invited to communicate other measures that they determine to be important.

Prevention and Health Promotion



What's Measured?

Community Collaboration

To promote community-wide adherence to principles of primary prevention and health promotion, plans are expected to collaborate with other local health plans on topics such as cancer screening, tobacco use, immunizations, and weight management. For instance, have common guidelines been established between plans on these issues? Have the plans collaborated on developing an immunization registry in the community?

Risk Factor Education and Measurement

Plans are expected to educate children and their caregivers on chronic disease risk factors such as family history, diet, physical inactivity, weight, cholesterol levels, and tobacco use. It is expected that a health risk assessment instrument and risk calculators are made available and promoted for member use.

Worksite Health Promotion

eValue8™ captures the capabilities for and history of offering programs to employers for on-site health promotion such as health fairs, customized printed materials, on-site screenings (for such measurers as blood pressure and weight) and lectures on health-related topics.

Prevention and Treatment of Tobacco Use

Plans are expected to offer programs for smoking cessation, including coverage of relevant pharmaceuticals and counseling.

Weight Management

Plans are expected to address obesity, which is a national epidemic. Plans are challenged to begin measuring prevalence of weight problems and to offer support to practitioners and members in forms ranging from simple body-mass index calculators to bariatric surgery options.

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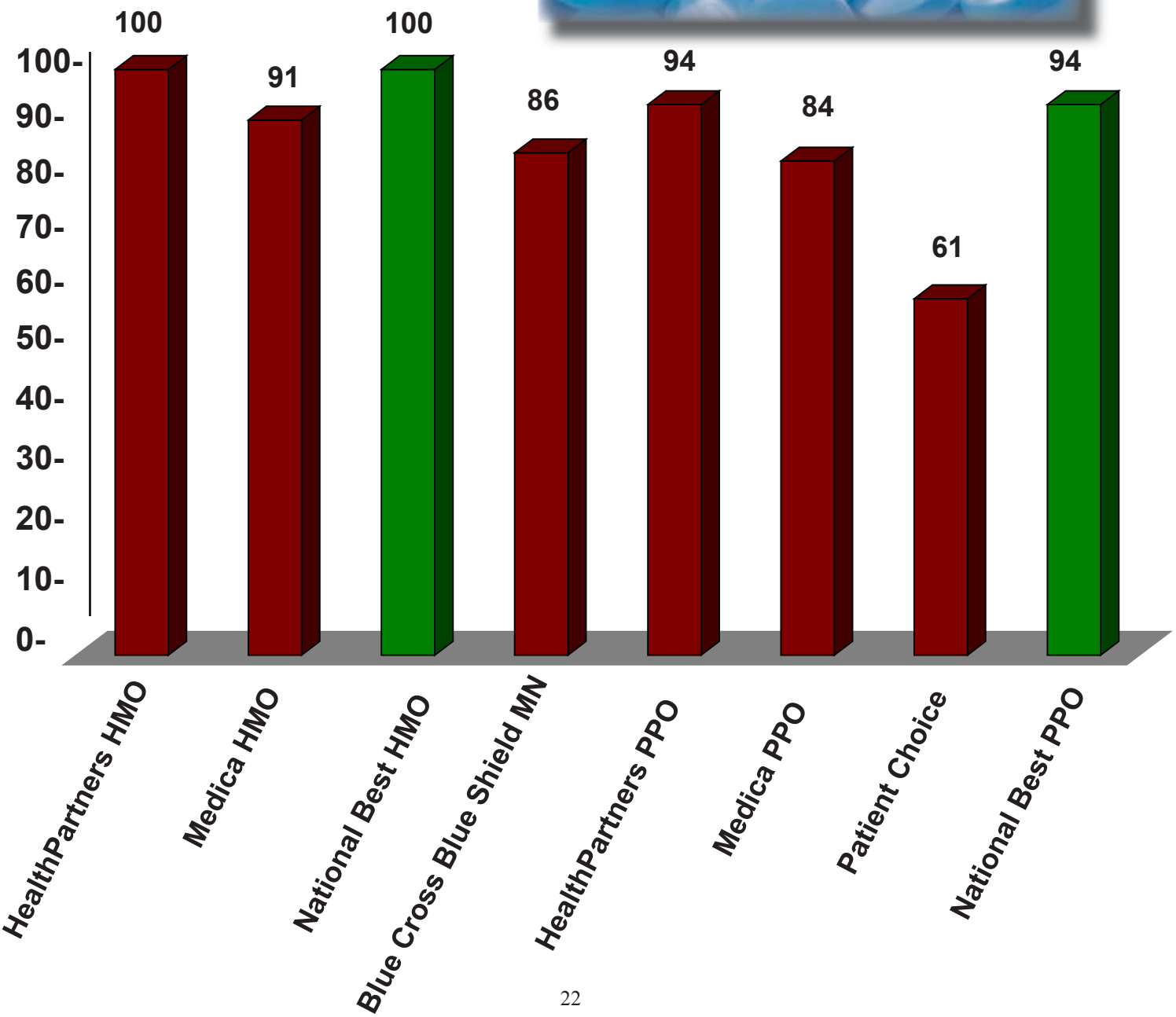
Outcomes

eValue8™ captures a range of standardized outcome measures including rates for immunizations, cancer screening, communicable disease screening, prenatal care, and well-child care.

Pharmacy Management

2006 eValue8™ National Best

HealthPartners HMO and PPO scored the highest in this eValue8™ category.



What's Measured?

Community Collaboration

eValue8™ asks health plans if they team up with other health plans and providers on initiatives to address antibiotic prescribing, medication errors and safety at point-of-service pharmacies.

Efficiency of Drug Use

eValue8™ places a significant emphasis on the health plan's programs to manage drug use and prescribing in the most efficient manner. Health plans are evaluated on their generic drug dispensing rates, strategies to use the most cost-effective drug in a given drug class, dose optimization (use of a drug that can be taken once a day instead of multiple times), and programs that encourage members to pick a low-cost drug. This module also examines the plan's management of specialty pharmaceuticals, such as biologicals, injectables, and chemotherapy agents. Among pharmaceuticals, such specialty medications are a fast-growing segment with the highest unit-cost.

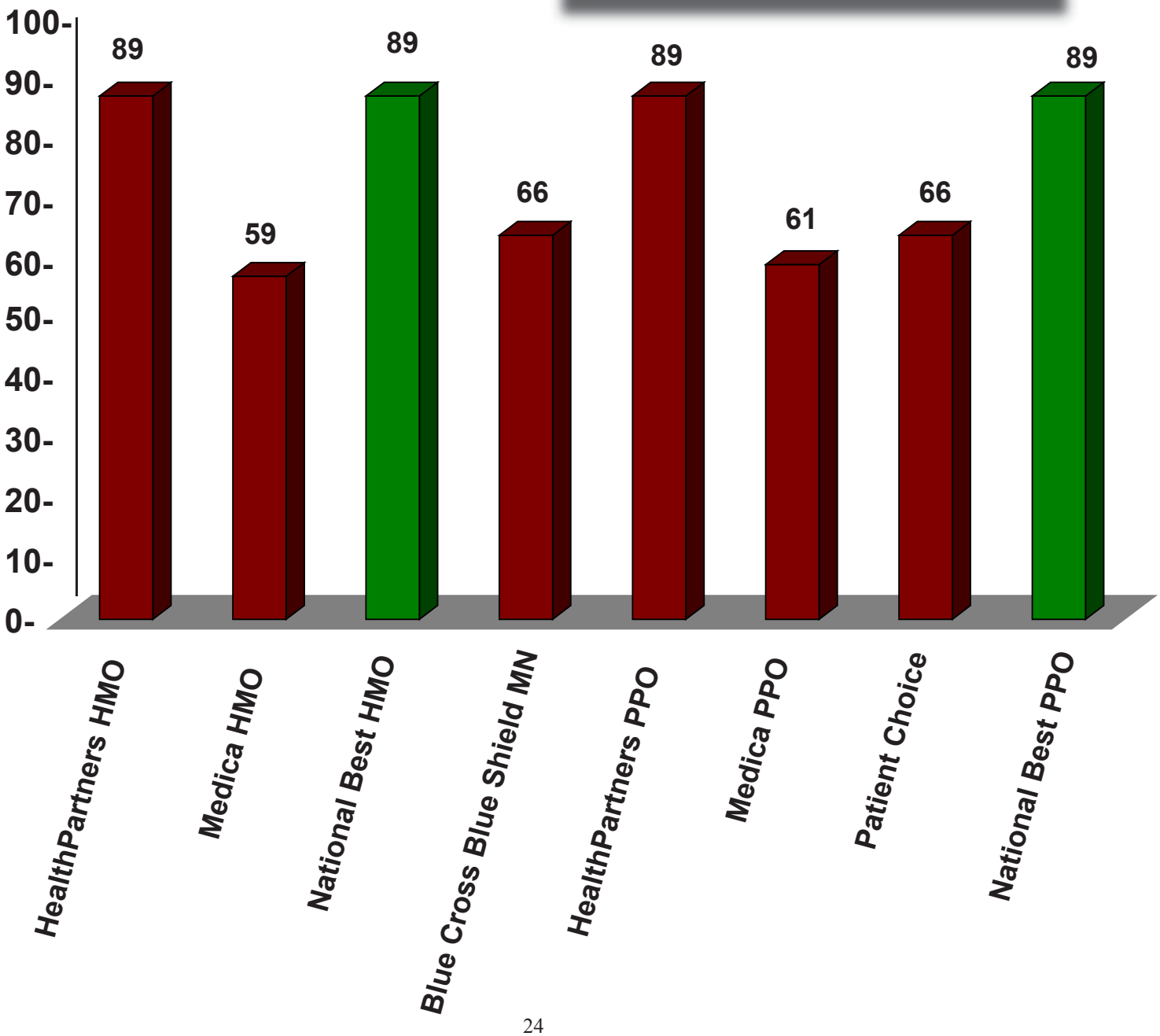
Quality

The quality sections ask health plans about whether and how they monitor safety and quality of the prescribing process from physician to the local point-of-service pharmacy. Health plans are evaluated on how they choose drugs for preferred drug lists, including whether they use a neutral evaluation service unaffiliated with drug companies. Other issues addressed in this section include how health plans monitor and solve problems with outpatient prescribing errors, efforts to reduce antibiotic use, and how they or their pharmacy benefit managers assess the integrity of point-of-service pharmacies in the networks.

Health Information Technology

2006 eValue8™ National Best

HealthPartners HMO and PPO scored the highest in this eValue8™ category.



What's Measured?

Structural Elements

eValue8™ examines the health plans approaches to implementing and using information technology to improve care and patient satisfaction. Health plans are asked if their information software uses open architecture so that information can be transported among plans and providers.

Community Collaboration

Plans are asked to identify their participation in local and regional programs to establish regional health information organizations, common security standards, and community-wide electronic prescribing.

Practitioner Support

Plans are expected to support practitioners administratively and clinically by providing an online system to determine patient eligibility, track submitted claims, make specialist referrals, and order and view lab and radiological test results. Plans also are expected to identify the extent to which practitioners use electronic prescribing. Plans are encouraged to provide incentives to physicians and hospitals to adopt electronic health records and electronic prescribing systems.

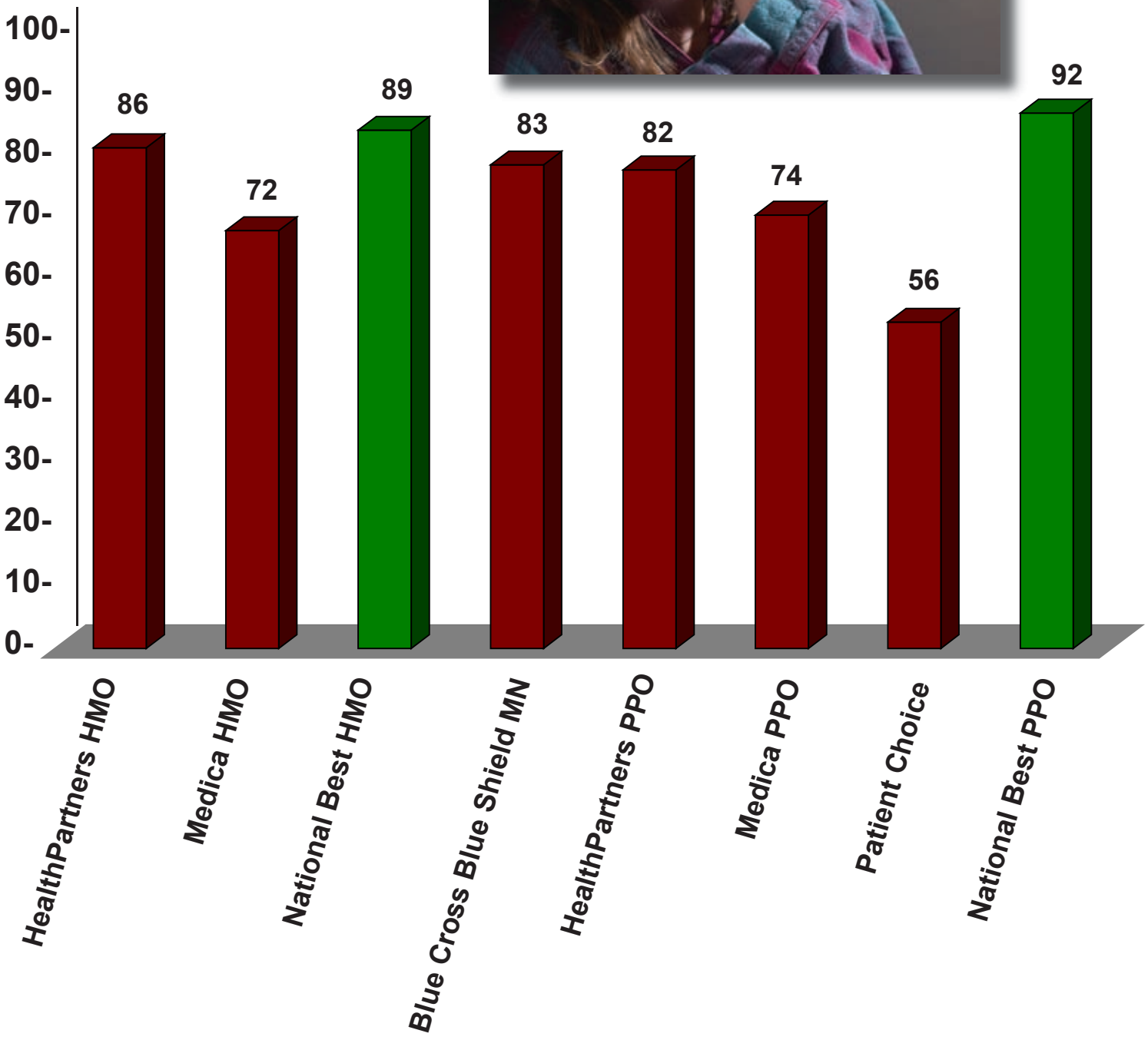
Member Support

Plans are expected to provide a variety of tools to members. These tools include personal health records that are populated with information from patients' claims and from patients' medication histories. Plans also are expected to allow patients to add content, such as over-the-counter drug use and immunizations provided at school.

Outcomes

Plans are expected to monitor and show an increase in the use of electronic forms of communication and information exchange compared with other forms of transaction. They are also expected to track member and practitioner satisfaction with online systems and information services.

Behavioral Health Screening & Management



What's Measured?

The behavioral health module evaluates health plans' programs for the management of depression and alcohol use among members. Health plans are asked to submit information on depression management and alcohol treatment programs.

Community Collaboration

Similar to the Chronic Disease Management (CDM) module, the Behavioral Health module credits collaboration with other local plans in the community in the use of clinical care guidelines, common screening tools it recommends, and the use of a clinical data registry. Health plans also are asked if they conduct periodic studies to ensure that a proper diagnosis was made for patients with behavioral conditions.

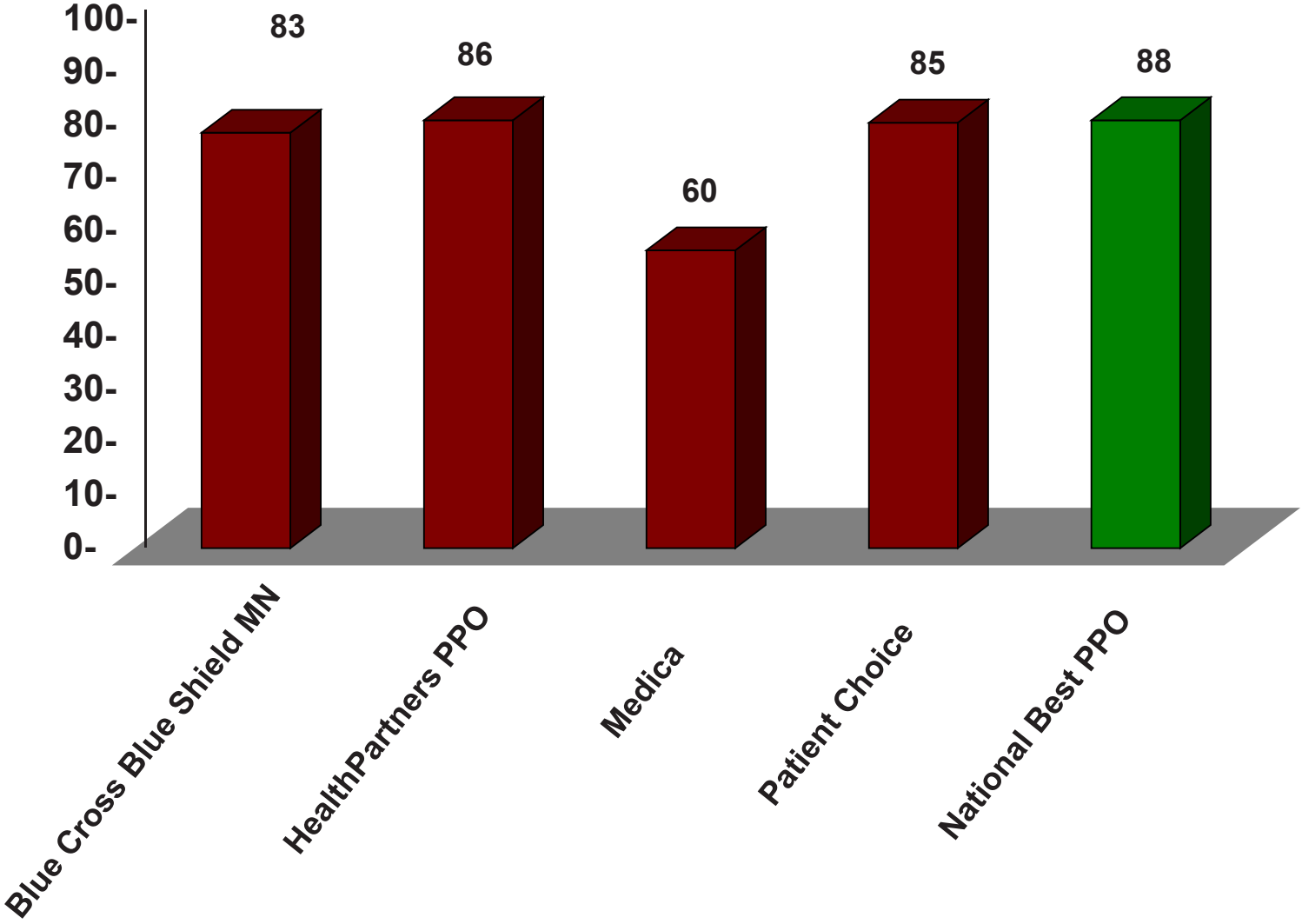
Practitioner Support

eValue8™ asks health plans about the support they provide to primary care physicians and to behavioral health practitioners, such as psychiatrists, psychologists, and other professionals who provide services to patients. Health plans are asked about which screening tools they recommend to these practitioners, whether the plans track their use, and if plans provide patient-specific and comparative reports for practitioners.

Performance Results

Plans are evaluated by their HEDIS results specific to depression and alcohol use disorders. Plans also disclose their use of the same set of non-HEDIS measures and are allowed to specify their own measures, such as the number of members diagnosed with depression who continue to comply with their treatment programs and the level of patient and provider satisfaction with the health plans' depression and alcohol treatment management programs.

PPO Operations



What's Measured?

The PPO Operations module captures information unique to preferred provider organizations that contract with employers or other third parties to provide medical care to a specified group of patients.

Contracting Strategy

eValue8™ identifies the method of updating fees and the average fee increases over time for primary care physicians, specialists, and hospitals. It also identifies average discounts by service type.

Access

The PPOs provide eValue8™ with their access standards and in-network use. A high degree of out-of-network use is an indication of an insufficient network.

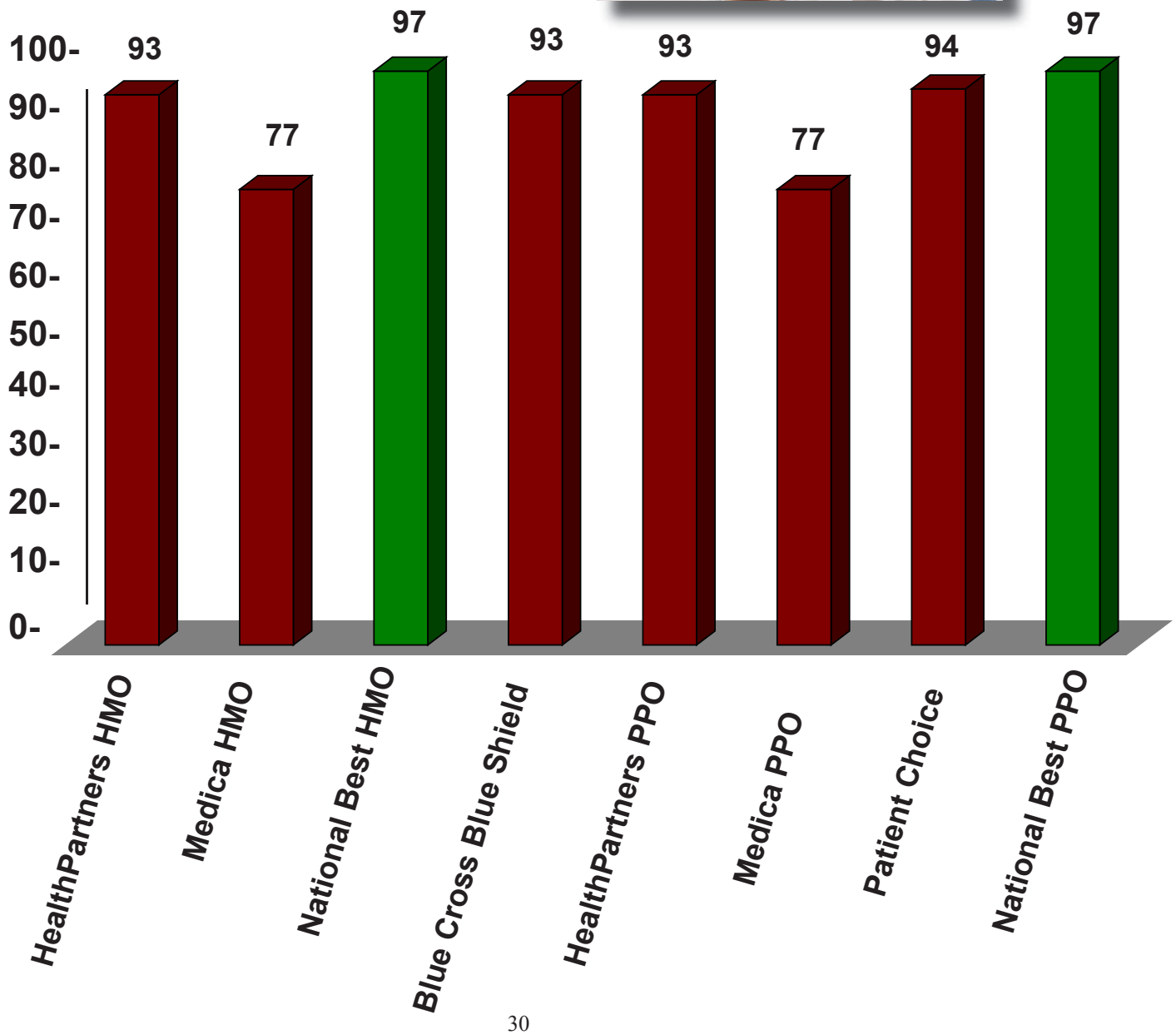
Utilization Management

This area helps determine the effectiveness and return on investment of PPOs utilization management program. The PPOs are asked about reduction in inpatient days and admissions diverted to lower-level care settings or to more efficient hospitals.

Claims Administration

eValue8™ inquires about PPOs' claims administration efficiency. The questions ask the PPOs whether they have received special accreditation in claims management and about their percentage of clean claims that are paid within 30 days. In addition, this section requires the PPOs to disclose the percentage of unpaid claims, payment, and processing accuracy, and their efforts to ensure that patient co-payments are accurately administered.

Consumer-Directed Health Plans



What's Measured?

The consumer-directed health plan (CDHP) module captures the features offered by plans for this emerging type of plan design. CDHP plans are characterized by high deductible options and health reimbursement accounts of health savings accounts.

Plan Design

This section measures the flexibility offered to purchasers in designing their CDHPs. Plans must offer a broad range of deductible options, waivers for preventive services, be able to reduce financial access barriers to essential services and provide flexibility for consumers to select design elements important to them.

Care Management

As consumers become more responsible for their health care decisions and more engaged with CDHPs, it is important that plans give them the tools needed to make good decisions. Some of those tools related to medical treatment decisions and support for self management of health and wellness and support for patients with chronic conditions. This section determines the range of support offered and the degree to which those tools are integrated with the plan's mainstream programming.

Financial Management

CDHP plans introduced financial management responsibilities that most consumers had never had to think about previously. The first-dollar responsibility to use their health reimbursement or health savings account funds exposes them to the price of all medical services. They therefore need support in the form of cost estimators and cost comparisons and basic balance accounting for their expenditures. Plans also need to provide tie-ins to IRS rules and provide related tax advice where appropriate.

Health Plan Information

Patient Choice

Year founded - 1997

Number of members - Approximately 80,000

Products

Patient Choice Care System Program features a network that tiers groups of health care providers and facilities called "care systems" on measures of cost and quality. Individuals choose a care system when they enroll. They can review comparative information about care system performance and have the option to contribute less toward their premium when selecting lower cost systems. Once enrolled, consumers obtain care from providers affiliated with their selected care system.

Patient Choice Insights is an open access three-tiered network that ranks physicians and hospitals on cost and quality factors and equips consumers to take control of their health care decisions. Consumers can access any provider in the network in any tier and at any time. Those who obtain services from network providers in a lower tier are generally rewarded through greater overall value and lower copayments and/or coinsurance.

Plan's View on Market Niche

"Patient Choice is a nationally recognized leader in creating value-based health care purchasing programs, winning the first ever national "Driving Value in Health Care Award in 2006. Our programs feature unique tiered networks that differentiate physicians, hospitals and other health care providers on measures of cost, efficiency and quality. Our pioneering approach enables consumers to gauge value and make informed choices about their health care-spurring health care professionals to compete on cost and quality and allowing employers to manage their health care costs."

Blue Cross Blue Shield of Minnesota

Year founded - 1933

Number of members - 2.7 million

Products Offered

PPO, HMO, POS, Indemnity, retiree plans and HRA/HSA products offered to Minnesota-based local and national employers and individuals. Products are integrated with a broad suite of population health management programs, analytics and web-based decision support.

View on Market Niche

"Blue Cross continues to carry out its purpose of making a healthy difference in people's lives, through the mission of promoting wider, more economical and timely availability of health services on both a local and national level thereby advancing public health and the art and science of health care. To realize that purpose, Blue Cross strives as a nonprofit organization to live out five key values: social responsibility, integrity, compassion, continuous learning and financial responsibility. We lead the nation in disease management and tobacco reduction as a means of making health care affordable. Blue Cross is committed to promoting quality health care by developing state of the art tools directed at engaging consumers and ensuring the transparency of meaningful provider information in a format that is useful and used. This information, together with network strategies such as multilevel networks, empower purchasers and consumers with choices that are transforming the delivery side of health care. In fact, Blue Cross just announced it is helping create the nation's largest medical database, which will improve purchaser benchmarking and benefit designs, inform provider quality initiatives, and even serve broader quality/cost purposes such as tracking efficacy of FDA-approved drugs and medical devices.

Health Plan Information

Medica

Year founded - 1974

Number of members - 1.3 million

Products

•Open Access Plans
•Care System Plans
•Consumer Directed Plans, including Health Savings Accounts (HSAs), Health Reimbursement Arrangements (HRAs), and Flexible Spending Accounts (FSAs)
•National Solutions
•Preferred Provider Organization (PPO)
•Medicare products including innovative prescription drug benefits
•Medicaid and Individual Plans
•Plans offering premium reductions for health improvement activities

Plan's View on Market Niche

"Beyond the delivery of outstanding health plan solutions, we recognize the opportunity we have to help our members lead healthier lives. Innovative health education and health improvement resources support members' efforts to improve their health. A range of programs and services inform, encourage and educate, leading to enhanced member well-being and lower health care costs for employers. We work with our members and providers to make health care accessible, affordable and a means by which our members improve their health. We apply our mission, vision and values – what we stand for – to our everyday business by providing freedom of choice; exceptional customer service; quality-first, member-first focus; easy access to care and wellness programs; innovative preventive care programs that provide something for every member, promoting wellness, not just managing sickness, and improving the health of the communities we serve."

Health Plan Information

HealthPartners

Year founded - 1957

Number of members - 650,000 medical and 230,000 dental

Products

•**Distinctions™ –** shows the cost and quality differences between clinics and hospitals.
•**Empower™ –** high-deductible plan with a health reimbursement account (HRA), a health savings account (HSA) or a Voluntary Employees' Beneficiary Association (VEBA) trust.

•**HealthPartners Open Access –** a coast-to-coast network offering companies with employees residing in Minnesota and other states health plan products using the HealthPartners and CIGNA HealthCare provider networks. Through our partnership with CIGNA, HealthPartners offers a national network of 470,000 providers and more than 4,800 hospitals, including top clinics and hospitals in every market. This alliance delivers a comprehensive, low-cost solution with one consistent national network, one plan administrator and one single point of contact.

Plan's View on Market Niche

HealthPartners is the largest consumer governed non-profit health care organization in the nation, and we are committed to improving the health of our members, our patients and the community. As a leading plan, payer and administrator, as well as a leading provider of care, HealthPartners is in a unique position to transform health care delivery and financing. We partner with providers, purchasers and members to produce superior results.

Provider Partnership: *We have a comprehensive provider network, and proactively measure and reward providers for producing higher-quality, more cost-effective care. We have competitive discounts and industry-leading pay for performance programs. We tier providers to assist members in understanding the quality and cost differences across our network.*

Member and Purchaser Partnership: *Exceptional customer service, health improvement and disease management programs along with health advocacy and decision support are core capabilities at HealthPartners. These features are integrated into all of our medical plans. We effectively identify members who need support to improve their health, engage these members in programs carefully tailored to enhance care, and deliver optimal health. We deliver the measurable financial results employers demand through robust reporting capabilities, and offer worksite health programs to complement plan coverage.*

PreferredOne

Year founded - 1984

Number of members - 450,000

Products

•**PreferredOne Community Health HMO**
•**PreferredOne Administrative Services -** self-insured health plans
•**PreferredOne Insurance -** providing reinsurance and individual/small business plans
•PreferredOne PPO

Plan's View on Market Niche

"Our focus is offering innovative and flexible benefit products to businesses with fewer than 1000 employees. We have expertise in Consumer-Directed Health Plans and 70% of our self-insured and fully insured employers are now providing this health plan benefit in their organizations."

Acknowledgements/Contact Information

BHCAG Members

- Allina Health Systems
- American Medical Systems
- Barry Wehmiller
- Berlex Laboratories
- Cargill
- Carlson Companies
- Ceridian
- ELCA Board of Pensions
- General Mills
- Glaxo SmithKline
- Honeywell
- Johnson & Johnson
- Jostens
- 3M
- Land O' Lakes
- Merck & Co.
- Medtronic
- MN Department of Employee Relations
- Olmsted County
- Park Nicollet
- Resource Training and Solutions
- Rosemount, Inc.
- Sanofi-Aventis
- St. Jude Medical
- Securian Financial Group
- SUPERVALU
- Target
- Tennant
- TCF Financial
- University of Minnesota
- Wells Fargo
- US Bank

Smart Buy Alliance Members

- BHCAG
- Minnesota Business Partnership
- Minnesota Chamber of Commerce
- State of Minnesota
  - -Minnesota Department of Human Services
  - -Minnesota Department of Employee Relations
- Labor / Management Health Care Coalition of the Upper Midwest
- CEO Roundtable
- Employers' Association
- Minnesota Association of Professional Employees (MAPE)

Data Evaluation Consultant

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